**CAMRD Scheduling Request Form**

|  |  |
| --- | --- |
| CAMRD Protocol Number |  |
| Appointment Date and Time |  |
| Subject ID |  |
| Subject Year of Birth |  |
| Time Point |  |
| Body Part and Laterality  (circle one if applicable) | Right Left Bilateral |
| Subject Height |  |
| Subject Weight |  |
| Gender assigned at birth | Male Female |
| Principle Investigator |  |

**For Contrasted Studies Only**

|  |  |
| --- | --- |
| Beta Hcg: Date **and** Value |  |
| Creatinine: Date **and** Value |  |

Printed Name of CRC Signature of CRC Date

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Please limit PHI to what has been outlined in the protocol and approved by the IRB.

For questions contact CAMRD MRI technologist at 919-684-7400.